Patient and Insurance Information

Patient Information

First Name:_____ Middle Name:_____ Last Name: _____

Street:_____ Zip:_____ City:_____ State:_____ Country: _____

Preferred Phone #:_____ Is this a mobile number? Yes ☐ No ☐

Who should we thank for referring you: _____

Email Address: _____

Date of Birth:_____ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact:_____ Emergency Phone #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name:_____ Middle Name:_____ Last Name: _____

Employer Name:_____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number:_____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name:_____ Middle Name:_____ Last Name: _____

Employer Name:_____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number:_____ Group/Contract Number:_____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Health History

Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other: _____

Height:_____ft_____in Weight:_____

Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name:_____ Physician's Phone Number: _____

Date of Last Physical:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other:_____

Are you taking, or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?
☐ No ☐ Yes How Long? _____

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Are you allergic or have you had an adverse reaction to any of the following?

☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex
☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

☐ None

_____

_____

_____

_____

_____

Check any conditions that apply to you:

☐ **None**

☐ Alcoholism

☐ Allergies or Hives

☐ Anemia

☐ Arthritis

☐ Artificial Joint/Pins

Type: _____

Age: _____

☐ Aspirin Therapy

☐ Asthma

☐ Blood Thinners

☐ Blood Transfusion

☐ Breathing Problems

☐ Cancer

Type: _____

☐ Chemotherapy

☐ Coumadin Therapy

☐ Dementia

Diabetes

Type: _____

Drug Addiction

☐ Epilepsy

☐ Excessive Bleeding

☐ Fainting/Dizziness

☐ Hearing Impairment

☐ Heart Murmur

☐ Heart Surgery

Date: _____

☐ Heart Trouble

Type: _____

☐ Hepatitis

Type: _____

☐ High Blood Pressure

☐ HIV

☐ Kidney Disease

☐ Liver Disease

☐ Low Blood Pressure

☐ Lung Disease/COPD

☐ Lupus

☐ Mitral Valve Prolapse

Mobility Impairment

NON-DENTAL Implants

Type: _____

☐ Organ Transplants

Type: _____

☐ Pace Maker

☐ Psychiatric Care

☐ Radiation Therapy

☐ Radiosurgery

☐ Rheumatic Fever

☐ Seizures

☐ Sexually Transmitted Disease

☐ Sinus Problems

☐ Stomach Problems

☐ Stroke

☐ Thyroid Disease

☐ Tuberculosis(TB)

☐ Ulcers

☐ Visual Impairment

☐ Other Disease/Illness

Type: _____

Dental History

Date of Last Dental Visit:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Date of Last Dental X-ray:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? ☐ Yes ☐ No

Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature:_____Date: _____

Dr's Signature/Medical History Review:_____Date: _____

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature:_____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

☐ all treatment information

☐ information specifically related to these treatment dates

Starting Date: _____ End Date: _____

Consent to obtain patient medication history (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature: _____ Date: _____

Payment, Insurance and Financial Arrangement Policies (signed by ALL new patients)

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

My Time Dental Centers is committed to providing exceptional service and treatment that addresses both your short- and long-term needs.

1. **A Clear, Written Estimate on your Cost of Treatment**
   Dr. Schmelter will provide you with a comprehensive treatment plan based on your overall health. You'll also receive a clear, detailed estimate of the cost of your plan, including your estimated insurance benefits. If you have questions regarding your insurance coverage, please contact your insurance company.

2. **Financial Agreement**
   a) I agree to pay a $35.00 Fee on all returned or cancelled checks.
   b) I understand there is a NO SHOW/ CANCELLATION FEE for all appointments. The may be a fee of $50 and will be charged per hour of time scheduled. **Please give 48-hour notice** if you are unable to keep your appointment.

3. **Payment Policy**
    a) Full payment of what you owe (called the Patient Financial Responsibility amount, as noted in your Treatment Acceptance and Payment Arrangement Form), is due when services are rendered. We accept cash, personal checks, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits, and select third-party financing programs.
    b) **10%** Discount for our uninsured cash/check paying patients, cannot be combined with any courtesy discounts.

4. **Refund Policy**

If you are reconsidering treatment you have not yet received but have already paid for, you may cancel treatment and request a refund at any time for the amount you paid. Note: Crown and bridge patients are responsible for the full cost of their treatment plan once preparation of your teeth has begun. Invisalign patients are responsible for the full cost of all laboratory costs and scan fees once fabrication of your aligns has begun.

Your refund request will be handled as follows:

• Original Form of Payment: Refunds will be applied to the original form of payment, with the exception of cash payments, which will be refunded by check.

• New Patients - 7 Days of Inactivity: If you are a new patient who hasn't had any treatment performed, has no scheduled appointments, and has a credit balance on your account, you will automatically receive, after 7 days of inactivity, either (a) a notice that you are entitled to a refund if you paid by cash or check, or (b) an automatic refund to your original form of payment if you paid by credit card or with third-party financing.

• 60 Days of Inactivity: Credit balances on accounts after 60 days of inactivity will be automatically refunded to the original form of payment, with the exception of cash/check payments, which will be notified by letter.

• Partial Denture Patients – 180 Days of Inactivity: Credit balances existing on accounts after 180 days of inactivity will be automatically refunded to the original form of payment, except cash payments, which will be refunded by check.

Timing of Refunds
Cash/Check: After receiving your refund request, we will confirm that your payment has cleared the bank (which may take up to 15 business days). Once cleared, you will be issued a refund check within 10 business days.

Credit Card/Third-Party Financing: Refunds will be issued to the form of payment within 3 business days after receipt of your refund request. Refunds for credit card payments may take up to seven (7) business days.

Three Ways to Request a Refund

- Contact **MY TIME DENTAL CENTERS 480.909.4255**
- Email a refund request to: info@mytimedentalcenters.com, or
- Mail a refund request to:

MY TIME DENTAL CENTERS
1941 W Guadalupe Rd
Suite 120
Mesa, Az 85202

5. **Dental Insurance**

If you have dental insurance, your insurance claim will be processed as follows:
•In Network: If your dentist is a participating provider in your insurance network, you will be billed according to the terms of your dentist's agreement with your insurer.

•Out of Network: If your dentist is not participating or in-network provider with your insurance plan, we will honor your carrier's in-network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.

Insurance Discounts: Insurance companies often negotiate discounts for services provided to their plan members. If you exceed your annual benefit limit the insurer's discounted rate may apply to additional services as a benefit to you.

6. **Third-Party Financing**
   My Time Dental Centers accepts payment from non-affiliated, third party finance companies. Credit decisions are the responsibility of these third-party finance companies. You may choose to pay all or a portion of your treatment using approved third-party financing products.

7. **Patient Communication**
   We'd like to keep in touch regarding your upcoming appointments, treatment plan, and treatment status. By providing your email address, phone number, and mailing address, you are giving My Time Dental Centers permission to contact you through one or all of these communication methods. Note that email and text messaging is not secure and there is a risk that they could be read by a third party. By sharing your email or mobile number with us you are acknowledging that you are aware of this risk and agree to receive this type of communication.